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Social phenomenological theory and methods are used to uncover, examine and understand the complexity of meanings and motives which precipitate social work practice. The meanings and motives were coded into five categories; worker, client, agency, other institutions, and noninstitutional meanings and motives. In addition, three theoretical concepts, operational themes, therapeutic worth of the client and operational dilemmas were developed and explored.

Social work interventions are a type of social action in which are embedded a complex variety of motives and meanings. As defined by Max Weber, social action is that action which...

> by virtue of the subjective meaning attached to it by the acting individual, takes account of the behavior of others, and is thereby oriented in its course.... In "action" is included all human behavior when and insofar as the acting individual attaches a subjective meaning to it. Action in this sense may be either overt or purely inward or subjective; it may consist of positive intervention in a situation, or of deliberately refraining from such intervention, or passively acquiescing in the situation. (Weber, 1957, p. 88).

"A failure to recognize and acknowledge this complexity can lead to oversimplified views of the process [of social work] and this in turn can have the effect of changing what is being studied" (Imre, 1985, p. 146). Using the data gathered in a previous study (Sachs, 1987) this paper aims at revealing this complexity. In addition, the practice implications and theoretical conceptual categories which have been developed are presented.

From 1983 to 1987 a social phenomenological study (Sachs, 1987) was undertaken aimed at discovering the precipitates of the practice interventions of social workers. Using Flanigan's (1954) critical incident technique, 23 M.S.W. social workers in

8 fields of practice were asked to write down one effective, one ineffective and one typical intervention they recently made with their clients. To get at the precipitates, i.e., the motives and meanings of the interventions, the workers were also asked to record what they thought influenced their making each intervention. Within a week of collecting the written reports the researcher followed up with a phenomenologically based interview in which workers were asked over and over and then again and again what else they thought might have influenced their making their interventions. All interviews were taped and lasted between one and three hours.

> Phenomenology begins with the strangeness of experience.... It involves a radical stance, a remarkable way of looking at things. That experience cannot be taken straightforwardly, that it is to-be-understood, introduces a mode of reversal into the ordinary and unreflective acceptance of the mundane course of affairs: a philosophical turn of mind signifies a shifting of perspective from simple placement in the world to wonder about it aslant. (Natanson, 1978, pp. 182, 184)

Through this methodology the workers' previously constructed taken-for-granted world became something for them to question.

> The taken-for-granted is always that particular level of experience which presents itself as not in need of further analysis. Whether a level of experience is thus taken for granted depends on the pragmatic interest of the reflective glance which is directed upon it and thereby upon the particular Here and Now from which that glance is operating. To say that some content of consciousness is thus taken for granted still leaves open as to whether any kind of existence or reality is credited to that content, i.e. whether it is given in acts of positional or neutral consciousness. Nevertheless, a change of attention can transform something that is taken for granted into something problematical. (Schutz, 1967, p. 74)

This mode of inquiry is, of course, not totally new to social work. In one or another modified forms workers, in acts of self-reflection or with their supervisors, examine their work with clients in this way. The intensity and rigor of phenomenology, however, does add a deeper dimension to what has been an

important, but too often prematurely dropped, element of inquiry into the complexity of the meanings and motives of practice. "Serious study," to quote Paulo Freire (1985), "requires not merely critical penetration into. . . basic content but also penetration into an acute sensibility, a permanent intellectual disquiet, a predisposition to investigation."

It is to the complexity of the meanings and motives of an intervention of one worker with her client that attention is now turned recognizing that even deeper complexities would have been uncovered had the investigation been continued. The data which were gathered from this worker will be used simultaneously (a) as exemplars of selected categories and theoretical concepts which were developed, (b) in juxtaposition to data from other workers to make a special point about a theoretical concept, and (c) as a starting place to make comments about implications for practice. The basic methodological grounding for this approach owes much to Glaser and Strauss' (1967) work on grounded theory and especially their discussion of the methods of constant comparative analysis and theoretical sampling.

The Worker, the Client, and the Intervention

Judy, the worker, was a 37 year old single white Jewish woman. She had worked for seven years, since her graduation from social work school, on the Neurological unit of a major non-profit hospital.

Bill, the client, was a 29 year old single Black Muslim man who had become quadriplegic as a result of an accident which took place while he worked as a judo instructor. The worker had been seeing the client for five months before she made the following intervention which she wrote in her preinterview report:

> Asked 29 yr. old Black quadriplegic man if "chest pains" he was experiencing was related to his feelings re: upcoming (next day) transfer to a chronic rehabilitation facility-

Analysis of the Meanings and Motives of the Intervention

In her written and verbal report Judy was able to identify over one hundred different precipitates of this practice inter-

vention. These and the precipitates of practice of other workers were coded into five major categories: meanings and motives of practice related to the worker's experiences of (a) the worker (or self), (b) the client, (c) the agency, (d) institutions other than the workers' agency, and (e) noninstitutional forces such as family and friends.

In addition, three higher level theoretical concepts, *operational themes, therapeutic worth of a client, and operational dilemmas* emerged as the data were examined. It is important here to underline the inductive nature of this method of category and theory development and to recognize that other conceptualizations are possible. Nevertheless, the concepts and categories were developed from and had to fit and work with the data.

> By "fit" we mean that the categories must be readily (not forcibly) applicable to and indicated by the data under study; by "work" we mean that they must be meaningfully relevant to and be able to explain the behavior under study. (Glaser and Strauss, 1967, p. 3)

Selected examples of the above categories of meanings and motives are presented below. Each set is followed by commentary relevant to selected theoretical and practice issues.

Meanings and Motives of Practice Interventions Related to the Worker's Experience of Herself

Judy reported the following things about herself (the worker) which influenced the intervention she made. All examples presented in the paper are transcribed verbatim from Judy's written report or the taped interview.

(a) . . . also pressures within me where I knew the work I still had to do with this kid and the short amount of time I had left within which to do it.

(b) Uh it also came out of my own feelings, I wanted to know that I had really done everything that needed to be done . . . to help. Also me feeling that I had done a complete job. I mean there were some of my needs there that I had really done the right thing for this kid.

(c) I'm a fairly direct person, um, especially with my patients . . . . No hidden agendas [a] social work value, although I guess it's also consistent with my personality.

(d) I have to say Bill Schwartz [her professor] was probably one of the more direct people I've ever worked with in my social work education and I guess almost from day one he taught me, you know, don't hide behind, if you have something on your mind lady, say it, cause you'll get into more trouble from what you don't say to a patient than what you do.

(e) I knew something was going to come up the day before he was going to transfer, not only because it would hurt him, because it always does. Seven years of working with neurosurgery patients.

(f) I would say that in my life there have been times when I've had hard times with separations, but I've also come through them all.

(g) They do teach it in school all the time that people need to separate, you know that in your relationship with a client, patient, you know that you have a beginning, middle and end, just like you have in an interview. Um, but it's more than that, uh, it wasn't just to do separation because the book said to do it. It was because I really believe in it.

Comments

(a) From Judy's comments related to this category the complex interplay of meanings and motives which precipitate a practice intervention can begin to be observed. Judy's feelings, values, life history, practice experience, formal knowledge, internalized mentors, and concerns about how she would see herself were each partial precipitants of the intervention.

(b) The content of the intervention as well as the content of many of the influences on practice which Judy described had to do with the interrelated themes of termination, separation and loss. The concept of *operational theme* (Sachs, 1989) was developed when it was observed that workers write and talk in metaphors or use words that repeat themselves over and over again often with high emotional intensity. The content of these themes vary from worker to worker. The force which a particular theme exerts on a particular worker's practice, however, is consistently powerful. For example, Judy's operational theme of loss sensitized her to Bill's imminent termination. The theme also partially precipitated the other two interventions

she reported and was probably a major reason she selected the unit she worked on. As she noted, "the unit and I are well suited."

It is useful for workers and supervisors to identify operational themes as one means to better understand a worker's practice. It is important to observe the practice situations in which an operational theme may be functional and in which situations it may be problematic. For example, another worker's operational theme, his need to maintain personal boundaries, precipitated his yelling and screaming hysterically at one of his clients who invaded his boundaries.

(c) Alfred Schutz (1967), the social phenomenologist, noted that all social action, which includes social work interventions, can be reduced to two types of motivational contexts. These are the social actor's *in-order-to-motives* and the social actor's *because-motives.*

In-order-to motives relate to the future and are inherent in what phenomenologists (Husserl, 1967; Schutz, 1967) call a project, i.e., a plan of action which is already more or less preconceived or fantasized by the social actor. For example, Judy's wish to do a complete and full job of terminating would be an in-order-to-motive.

Because-motives, on the other hand, have to do with a social actor's past experience in the world. They "explain the project in terms of the actor's past experience" (Schutz, 1967, p. 91). For example, Judy's education and training dealing with separation, as well as her operational theme related to termination, separation and loss would be because-motives which, in part, precipitated her intervention.

Ultimately, all categories of motives for a worker's intervention can be reduced to a set of because-motives related to a worker. All the categories of meanings and motives described in this paper were mediated through a worker. They were experienced by a worker, interpreted by a worker and given meaning by a worker. The workers reported their experiences to the researcher and it was from these reports that categories were developed.

Meanings and Motives of Practice Interventions Related to the Worker's Experience of the Client

(a) Patient had a history of using symptom-focused complaints/concerns to express his anxieties and feelings.... Despite patient's history of symptom-focused behavior, he was often able to utilize direct approaches (or possible interpretations) to explore concerns further-He was a bright, sensitive and quite self-aware young man.

(b) The chest pain was symbolic of the heart ache he felt re: leaving all of us- it was not only anxiety related.

(c) The look I saw on his face the day before, you know, when we were talking about the fact that he would be going.

(d) One of the things I also felt was that the strength of the relationship and the trust that we had for one another was that, even though it might be risky and he might deny it, it wasn't going to damage my ability perhaps to go at it from a different way if I had to, and then alright it might take longer. We may not do some of the other things I wanted to do with him. But those other things were secondary in comparison to really getting to talk about some of his feelings about the leaving.

(e) I guess I wanted to help him to leave so that he wouldn't be angry at us and feel like he was being kicked out in any way because he was not. But I wanted him to have nice feelings about us but still not be infuriated, you know.

(f) Because I really felt like my job was to help him be ready for the next step..., to make a nice adjustment...at the new place.

Comments

(a) All the workers who were interviewed were sensitive to their client's feelings. Workers wanted their clients to experience and/or talk out their feelings of loss, hopelessness, fear, frustration, anger etc.

Client anger, however, was the most discussed emotion and the one which many workers appeared to have the most difficulty with. This was particularly true when a client's anger was directed at the worker or her agency. Judy, for example,

didn't want Bill to be angry at her. She preferred him to have "nice feelings."

Angry feelings were seen by many workers, including Judy, as dangerous. They might be displaced or "acted out." Judy was concerned that if termination was not worked through that Bill would get angry and would create problems for himself (and guilt for her) if he acted out his anger at the rehabilitation agency: "I mean, let me tell you, the fastest way to alienate people when you first come into a new hospital is to be angry and he would have acted it out."

For most workers anger was to be reduced or gotten rid of. If the clients did not get rid of their anger they would often be negatively labelled as resistant, defensive, or hard to reach. The exceptions to this were workers whose operational theme related to assertiveness/aggressiveness and/or workers who had a solid theoretical framework from which they could work with a client's anger. The first group saw anger as understandable, to be encouraged and as healthy. The second group of workers saw anger as something to be understood, explored and interpreted. For example, one worker wanted her depressed client to express his anger at her because she believed the roots of his depression lay in his repressed anger.

Schools of social work and supervisors would do well to pay more attention to this powerful emotion which workers, agencies and clients too often wish to surpress or keep under repression.

(b) Judy's description of Bill as a bright, sensitive, self aware young man who was open to insight are examples of a few of the properties which emerged in relation to the theoretical concept *therapeutic worth of the client* (Sachs, 1989). Once calculated the therapeutic worth of a client is predictive of the kind and quality of care that a worker will give to a client. It influences the amount of time a worker is willing to spend with a client, and thoughtfulness and sensitivity a worker shows to a client, and a worker's willingness to go out of his/her way for a client.

Several factors are useful in calculating a client's therapeutic worth. (1) The extent to which a worker experiences a client

as engaged in and motivated for treatment. The greater the motivation the higher a client's worth. (2) The extent to which clients display gratefulness for the workers' help. The more grateful clients are the higher their worth. (3) The client's degree of deprivation or difficulty. The greater degree of deprivation the greater the client's worth. (4) The length of time a client has been seen by a worker. The longer the time the higher the worth. (5) The degree to which clients direct anger at a worker or the agency. The greater the anger the lower the client's worth. (6) The extent to which a client is an object of positive worker identification. The more a worker is identified with a client the greater the client's worth. (7) The age of a client. Younger clients generally had higher therapeutic worth (Sachs, 1989).

Bill had high therapeutic worth for Judy. "I like this kid . . . who has tried so damn hard all his life. . . . He was working his way off welfare. . . . He was a wonderful treatment case . . . because he was so emotionally available."

But Judy also had clients who had low therapeutic worth for her. "I have had dirt balls . . . you know I mean drug abuser types . . . and I have to tell you that even though I lay out the things that are available and I try to help them get it, without their cooperation, and they don't sustain any kind of cooperation, and they're real sociopaths you know. . . . I'm not going to keep knocking my head against the wall."

Therapeutic worth can, however, be calculated differently by other professionals (Glaser and Strauss, 1964, 1967). For example, Judy described one doctor on her service who talked about Bill as a talking head and wondered whether they should resuscitate him the next time he needed it.

Therapeutic worth is a powerful concept which defines the kind and quality of treatment that will take place. Faculty, and supervisors as much as workers develop calculi for a client's therapeutic worth which are then used to determine treatment modalities, how well or poorly a client will be treated and on some occasions whether a client will be treated at all. In a field that prides itself on delivering services to those most in need it is important to understand the calculations that go into the delivery of services.

(c) Ricoeur's (1970) work on hermeneutics and interpretation is highly relevant to this study. He points out that "all behavior is multiply determined" (p. 348). In addition, behavior as a symbol is overdetermined. Similarly, any precipitate of behavior, e.g., a worker's values, knowledge, feelings, or the value she or he places on a client are overdetermined and therefore subject to a variety of plausable interpretations. This is why the same report of a worker about what influenced a practice intervention could be coded into more than one category. It was not the mutual exclusivity of data interpretation and coding that was observed, but the rich, complex, overdetermined and multifaceted nature of the human lives and behavior of social workers that emerged. For example, Judy's statement, "I knew he trusted me enough to be willing to share and explore feelings directly," could be and was coded both under a worker's knowledge of the client and the client's feelings about the worker. No doubt other codings would be possible.

Meanings and Motives of Practice Interventions Related to a Worker's Experience of the Agency

Under this category were coded precipitates of practice that related to an agency's goals, functions and purposes, the agencies policies, different agency structures, the worker's supervisor, other staff, and other client's in the agency.

(a) Staff [nurse] had already tried "indirect" approaches (blood gases, listening to heart, pulse and respiration checks, [as] explanations of possible causes [of chest pains].

(b) I was also responding to the nurse who was saying, "what am I going to do, what am I going to do." He's starting to have chest pains....

(c) Once someone is no longer acute...one works on discharge.... I mean people would say, O.K. when is he going...? I also know that some of when they say, where's he going, very often doesn't have to do with this patient so much as it might have to do with other pressures elsewhere on the floor.

(d) Directness...fits, I have to say, with the hospital style ...and doctors are direct.

(e) . . . and he had some ties to some of the staff members here, some of the nurses in particular that were so very strong that he had this place built up as the only place that he could get, help him with anything. And quite frankly we had reached the limit a couple of months ago of what we really could help him accomplish.

Comments

(a) Judy was aware of but appeared less influenced by her agency's policies and structure than most workers interviewed. She was one of the few workers who actively "worked the system" for the benefit of her clients. The reasons for this appeared related to her intensely held personal and professional values which were in the direction of independence and control over one's life. When the doctors and other staff on the unit asked her, "when is he going" she described herself replying "that he could go now, but he's likely to spike a fever and be back tomorrow," i.e., she invoked one agency policy "don't compromise a patient's health" against another agency policy "discharge when no longer acute."

Other workers interviewed were less gutsy. They feared for their jobs and followed agency policy even when they knew it was clearly against a client's interests. For example, a child care worker would not refer her client to a better group home because it was agency policy to refer only to group homes within the agency.

(b) Workers were uniform in their belief that their agencies had too few workers, who had too little time, to see too many clients. Judy felt she would have no time to follow up her work with Bill when he went to the rehabilitation agency. As a result she felt she needed to ask an interpretive question rather than explore his symptoms as she usually did. She needed to quickly terminate rather than take the time both she and he needed. The theoretical concept *operational dilemma* has been developed to better understand and clarify this type of situation.

Operational dilemma refers to the more or less difficult, conflictual, contradictory, ambiguous, ambivalent and problematic choices workers are faced with in the performance of their work. Operational dilemmas are ubiquitous to the practice of social

work and there has already been much written about them. Lowenberg and Dolgoff (1982) developed a comprehensive set of categories which described professional dilemmas and Ohlin (1958) did work related to the responses that workers made to the dilemmas they faced in probation and parole.

The tremendous variety and variability of intrapersonal, interpersonal and institutional forces which precipitate, motivate and give meaning to a practice intervention are the seeds from which operational dilemmas grow. The variety and variability of practice precipitates create a series of dialectics for workers which are compromised in their interventions and often remain unresolved. Compromised here means that an intervention, like a dream symbol or a symptom, is often the result of a conflict but contains embedded within it the roots of that conflict. For example, a social worker who worked for the Fire Department routinely told his clients not to tell him that they used drugs since it was his agency's policy that he report illegal drug use. Compromised in this intervention is the agency's policy on drug use, his professional value about maintaining confidentiality, and the firefighter's work culture which holds that you don't rat on your fellow workers. The essential conflict for this worker, however, remains unresolved and he must deal with his dilemma over and over again as he meets new clients.

Two measures of operational dilemmas are suggested which might be predictive of the degree of stress, tension, anxiety, and alienation workers are likely to experience on the job. The first measure is the degree of conflict among the precipitates of a practice intervention. The second measure is the value which a worker places on a particular precipitate of practice.

Workers need understanding and guidance from faculty and supervisors to identify, possibly resolve or learn to live with the operational dilemmas they face. The phenomenological methods used in this study may be one useful tool to begin this process.

Meanings and Motives of Practice Interventions Related to a Worker's Experience of Institutions other than the Agency.

Judy reported general examples of precipitates in this category.

(a) Patient due to transfer next morning and I felt he needed to work through feelings related to separation from staff that had "saved his life" and literally met every care need for past 5 months- Chronic facility gave us 24 hours to do this in!

(b) I was very concerned about his ability to make a connection to people there and utilize the services they had to offer. . . . It was crucial because. . . when you go to those chronic rehab facilities, they do not always have the perseverance and the resources that our particular neurological service has to really pull people through and they just might dump him in the back and leave him there forever.

(c) I mean it's usually not a problem [pressure to discharge], but it might come from some utilization review committee getting on some doctor's case.

(d) Their chronic rehab is damn good. . . and maybe they will get him vocational rehabilitation and maybe teach him something like computer programming or something that can be done with mouth control.

(e) With a chronic institution the waiting lists are very long. . . , a year or two years. . . . When this kid first heard it could take up to a year before he went to rehab, he went into a two week long funk, severe depression.

Comments

(a) One concern for many workers who refer a client to another agency is whether or not the match will take. Judy's intervention was, in part, motivated by her wish to help her client act in a way that would insure his being received well by the staff of the other agency. She didn't want the termination process to generate anger that might be "acted out" at the rehabilitation agency.

Other workers were more concerned with protecting their relationship with the agency to which the referrals were made. A settlement house worker, who did job development, was not going to "ruin [her] relationship with a corporation by sending them someone who [she] believed was not going to work out."

(b) The monitoring agency mentioned by Judy in her report was the utilization review board which wanted patients to be discharged in a timely fashion. The review board though having

little, if any, impact on Judy's intervention with Bill does, of course, have an increasingly powerful impact on medical social workers' work with clients.

Monitoring agencies could be the decisive force which precipitates a worker's practice. An arbitration judge, for example, demanded that an industrial social worker write a letter indicating that her client was attending sessions or he would rule in favor of the employer and the client would lose his job. The worker, who preferred to work slowly with clients who had sporadic attendance, felt obliged to follow the judge's demands. With much anguish she informed her client that "[he] had to come to sessions every week or else. . . !"

The above example of an operational dilemma raises the question whether social work can be done in certain settings. In industry or the field of corrections social control functions may be so powerful an influence in precipitating practice that central social work values such as client self-determination are compromised beyond repair.

Meanings and Motives of Practice Interventions Related to a Worker's Experience of Noninstitutional Forces.

The precipitates of practice which Judy reported in this category related to the client's family and her own mother.

(a) Long ago worked on discharge plans. . . with family.

(b) The fastest way to alienate people when you first come to a new hospital is to be angry and he would have acted it out. . . . I know from how he and his family started to act with us in the beginning. They were infuriated with all of us.

(c) My mother used to always say, "never go to bed angry, you always have to make up," O.K., before you know. It was like forbidden. No matter what your feelings were, you had at least give the kiss good night and make up. . . . There's a piece of that that I think is operating here and that is I really believe in process and working through things and seeing issues to their completion.

Comments

(a) Judy saw the family's potential for anger as a threat to the overall course of treatment. It was another factor in her

asking an interpretive question that might open a discussion of angry feelings related to termination rather than exploring Bill's symptoms.

Other workers, however, saw the family or friends of their clients in other ways, e.g., as cotherapists, advocates. They were important support systems which could decide a treatment intervention. A worker in a mental hospital was willing to discharge one of her patients because she knew he had a girlfriend who he would live with and who would take care of him.

(b) In Judy's comment about her mother the early meanings of her feelings about anger and separation may be seen. A psychoanalyst might label this the countertransferential element in the precipitation of a practice intervention. It is sufficient for our purposes to suggest that it is another element in the complexity of intrapersonal, interpersonal, and social institutional forces from the past and present which interact at the psychosocial interface to precipitate worker interventions with clients.

Summary, Limitations and Conclusion

Social phenomenological theory and methods were used to uncover, examine and understand the complexity of meanings and motives which precipitate social work practice. The meanings and motives were coded into five categories; worker, client, agency, other institutions, and noninstitutional meanings and motives. In addition, three theoretical concepts; operational themes, therapeutic worth of the client and operational dilemmas were developed and explored. Phenomenology is well suited as a research tool to help social workers explore and understand their practice. In this method workers

> are asked to evaluate the objectivity or a claim to knowledge according to their reflexive self-related understanding of the basic features of social interaction and human communications as well as their common-sense knowledge of cultural meanings. The positivistic approaches promoted a normative conception of objectivity; the alternatives support an interpretive one. (Johnson, 1975, pp. 209–210)

Phenomenological theory and methods are not, however, a panacea. Judy barely examined the meanings that race, religion

and gender had for this intervention. In addition, it was only after reviewing the transcript of the two and a half hour interview that the researcher recognized that Judy often referred to this 29 year old black man as "kid." Perhaps it was only the need for more time, or the unphenomenological presumption that they had meaning, but the possible influence and meanings of these factors were not explored. Quantitative theory and methods should not be abandoned. As Bateson (1979) expressed it, "two views are better than one."

Judy's reflections on the process supports the usefulness of this research method and its implications for practice. She will have the last word.

> It was good because it gave me a chance to be a little more reflective and gain a little more closure.
>
> It made what is generally a chore, O.K., something that I could really use and rethink my practice and stuff like that.
>
> I could sit and do something like this and think for hours and keep coming up with new stuff and new values. . . . I think how close the mesh is between what my personal issues are and the issues my particular service has and maybe why I self-selected this service to begin with, where I wanted to, you know. I think that that has crystalized or conceptualized even more finally as a result of this.
>
> I'm not new, but I do think that I'm always growing and always changing and in that sense this is very helpful. . . . It's been fun for me.

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